



-The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 833-230-2099. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 833-230-2099 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$6,500 individual/\$13,000 family per Benefit Year	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$9,100 individual/\$18,200 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.caresource.com/marketplace">www.caresource.com/marketplace</a> or call 833-230-2099 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Network Provider Information*
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Zero Cost Telehealth Partner	No charge	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat an injury or illness.	No charge	\$30 copay	Not covered	None
	<a href="#">Specialist</a> visit	No charge	\$70 copay	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test†</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	X-ray: \$200 copay after deductible Lab: \$40 copay	Not covered	None None
	Imaging (CT/PET scans, MRIs)	No charge	\$250 copay after deductible	Not covered	None
<b>If you need drugs to treat your illness or condition†</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caresource.com/marketplace">www.caresource.com/marketplace</a> .	Preventive drugs	No charge	No charge	Not covered	Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for any drug in Tiers 0-3 All others limited to a 30-day supply Any copays shown are for a 30-day supply. 90-day supplies are 3 times the copay. Insulin cost share not to exceed \$100 per 30-day supply
	Generic drugs	No charge	Up to \$15 copay	Not covered	
	Preferred brand drugs	No charge	Up to \$75 copay	Not covered	
	Non-preferred brand drugs	No charge	40% coinsurance after deductible	Not covered	
	<a href="#">Specialty drugs</a>	No charge	50% coinsurance after deductible	Not covered	

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 833-230-2099.

†Prior authorization may be required, for more details see [www.caresource.com/mp-WV-pa](http://www.caresource.com/mp-WV-pa).

\*\*In addition to any visits covered under chronic pain treatment benefit

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Network Provider Information*
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out of-Network Provider (You will pay the most)	
If you have outpatient surgery†	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	No charge	50% coinsurance after deductible	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	\$500 copay after deductible	\$500 copay after deductible	Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department.
	<a href="#">Emergency medical transportation</a>	No charge	50% coinsurance after deductible	50% coinsurance after deductible	None
	<a href="#">Urgent care</a>	No charge	\$50 copay	\$50 copay	If you receive services in addition to <a href="#">urgent care</a> , additional <a href="#">copayments</a> , <a href="#">deductibles</a> , or <a href="#">coinsurance</a> may apply.
If you have a hospital stay†	Facility fee (e.g., hospital room)	No charge	\$500 copay after deductible per stay	Not covered	None
	Physician/surgeon fees	No charge	No charge after deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	No charge	\$30 copay for office visits and 50% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services	No charge	\$500 copay after deductible per stay	Not covered	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Network Provider Information*
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	\$70 copay	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services†	No charge	No charge after deductible	Not covered	
	Childbirth/delivery facility services†	No charge	\$500 copay after deductible	Not covered	Your cost for inpatient services only. See above for physician delivery charges.
If you need help recovering or have other special health needs	<a href="#">Home health care</a> †	No charge	50% coinsurance after deductible	Not covered	Private Duty Nursing limited to 35 visits per Benefit Year. 100 visits per Benefit Year for other services. Refer to your Evidence of Coverage for additional information.
	<a href="#">Rehabilitation services</a> †	No charge	\$30 copay	Not covered	PT**, OT**, Manipulation therapy**, Pulmonary limited to 30 visits each per Benefit Year. Cardiac limited to 36 visits.
	Physical/Occupational therapy	No charge	50% coinsurance after deductible	Not covered	
	Speech/Post-cochlear implant aural therapy	No charge	50% coinsurance after deductible	Not covered	
	All Other Services	No charge	50% coinsurance after deductible	Not covered	30 visits per Benefit Year
	<a href="#">Habilitation services</a> †	No charge	\$30 copay	Not covered	
	Physical/Occupational therapy	No charge	50% coinsurance after deductible	Not covered	None
	Speech therapy	No charge	50% coinsurance after deductible	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Network Provider Information*
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out of-Network Provider (You will pay the most)	
	Manipulation therapy	No charge	50% coinsurance after deductible	Not covered	Manipulation therapy** limited to 30 visits per Benefit Year.
	Chronic Pain Treatment	No charge	50% coinsurance after deductible	Not covered	20 combined visits per event
	<a href="#">Skilled nursing care</a> †	No charge	\$500 copay after deductible per stay	Not covered	None
	<a href="#">Durable medical equipment</a> †	No charge	50% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
	<a href="#">Hospice services</a>	No charge	50% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	1 routine eye exam per Benefit Year
	Children's eyewear	No charge	No charge	Not covered	Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed.
	Children's dental check-up	No charge	No charge	Not covered	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Adult orthodontia</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Hearing Aids</li> <li>Long term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>	

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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Dental care (Adult)<ul style="list-style-type: none"><li>• No charge for preventive services</li><li>• 30% coinsurance for minor services</li><li>• 50% coinsurance for major services</li><li>• \$1,000 annual allowance</li></ul></li></ul> | <ul style="list-style-type: none"><li>• Fitness Benefits – Gym membership, at home kits, online videos, coaching, and more</li><li>• Infertility treatment</li></ul> | <ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Routine eye care (Adult)<ul style="list-style-type: none"><li>• \$40 copay for eye exam with retinal imaging included</li><li>• No cost for glasses or contacts, with \$250 annual allowance</li></ul></li></ul> |
|---|--|---|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-888-879-9842. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: West Virginia Department of Insurance: 1-888-879-9842.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Not Applicable**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 833-230-2099

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-230-2099

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 833-230-2099

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 833-230-2099.

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You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at [CareSource.com]. You may also contact us at 1-855-202-0622 to request a copy.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">coinsurance</a>	50%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$6,500
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$7,560</b>
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### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">coinsurance</a>	50%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,900
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$4,520</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">coinsurance</a>	50%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$2,400</b>
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Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 833-230-2099 Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services